CHECK REQUEST

PAYEE (VENDOR) FULLERTON INTERNAL MEDICINE

VENDOR #

AMOUNT $579.20

REASON MEDICAL EXPENSES FOR REV. [redacted] 1/11/88 TO 10/10/88

REQUESTED BY [signature] DATE 7/2/89

DEPARTMENTAL APPROVAL

Mailed 7-17-89

AUTOMOBILE	
FUEL	011
REPAIRS	012
BOOKS, MAGAZINES	021
DUES, SUBSCRIPTIONS	022
EDUCATION	050
PROFESSIONAL	
CONSULTANT	092
FACILITATOR	093
LEGAL	094
POSTAGE	062
PRINTING	070
PROMOTION/PUBLISHING	
OFFICE	061
CHAPEL	063
COMPUTER	065
TRAVEL & EXPENSE	100
WORKSHOP-ATTENDED	111
WORKSHOP-SPONSORED	112

INVOICE DATE

BANK # 110-101

VENDOR #

CHECK COMMENTS

INVOICE #

INVOICE AMOUNT

DISTRIBUTION

A/C AMOUNT

A/C AMOUNT

A/C AMOUNT

APPROVALS

The Prudential Insurance Company of America Claim Services Provider

If you have any questions about this claim, or wish a review of the decision, please contact →

PRUCARE OF SOUTHERN CALIFORNIA
PRUDENTIAL PLUS OF SO CAL
PO BOX 85793
SAN DIEGO, CA 92138
(800) 433-3150

JUNE 13, 1989

ELEUTER V RAMOS
2811 EAST VILLA REAL DRIV
ORANGE CA 92667

CHECK #: 0049221

CHECK AMT: $579.20

MMPO-ID: 6J6

PATIENT #:

CLAIM #: 89163000286

EE SSN: [redacted]

PATIENT NAME:
RAMOS ,ELEUTER V

SUBSCRIBER NAME:
RAMOS ,ELEUTER V

Rec'd ck #0049221
6/16/89 ($579.20)

50600142

PRUCARE OF SOUTHERN CALIFORNIA
PRUDENTIAL PLUS OF SO CAL
PO BOX 85793
SAN DIEGO, CA 92138

(800) 433-3150

EXPLANATION OF BENEFITS
PRUDENTIAL INSURANCE COMPANY OF AMERICA

IF YOU HAVE ANY QUESTIONS ABOUT THIS CLAIM OR WISH A REVIEW OF THIS DECISION, PLEASE CONTACT THIS OFFICE.

DATE: JUNE 13, 1989
CONTROL#/BRANCH: 78207 01
ID#:
EMPLOYEE: SAME AS PATIENT
PATIENT: ELEUTER V RAMOS
MMPO#: 6J6
CLAIM#: 89163000286 DB
PROVIDER NAME: FULLERTON INTERNAL MED

THIS IS NOT A BILL.

ELEUTER V RAMOS
2811 EAST VILLA REAL DRIV
ORANGE CA 92667

NATURE OF SERVICE	DATES OF SERVICE FROM	DATES OF SERVICE TO	CHARGES	SUPPLEMENTAL BENEFITS	EXCLUDED AMOUNT	EXCLUDED CODE	EXCLUDED AMT AFTER	DEDUCTIBLE APPLIED	DEDUCTIBLE AMT AFTER	BENEFIT %	BENEFIT AMOUNT
DIAGNOSTIC	02/08/88		210.00		210.00	38	0.00	0.00			0.00
PHYSICIAN SVC	02/08/88		37.00				37.00	0.00	37.00	80	29.60
PHYSICIAN SVC	03/14/88	03/14/88	121.00				121.00	0.00	121.00	80	96.80
PHYSICIAN SVC	03/15/88	03/15/88	47.00				47.00	0.00	47.00	80	37.60
PHYSICIAN SVC	03/16/88	03/16/88	47.00				47.00	0.00	47.00	80	37.60
PHYSICIAN SVC	03/17/88	03/17/88	63.00				63.00	0.00	63.00	80	50.40
PHYSICIAN SVC	04/11/88		40.00				40.00	0.00	40.00	80	32.00
DIAGNOSTIC	04/11/88		49.50				49.50	0.00	49.50	80	39.60
DIAGNOSTIC	04/11/88		22.00				22.00	0.00	22.00	80	17.60
DIAGNOSTIC	04/11/88		12.50				12.50	0.00	12.50	80	10.00
DIAGNOSTIC	04/11/88		23.00				23.00	0.00	23.00	80	18.40
PHYSICIAN SVC	07/11/88		40.00				40.00	0.00	40.00	80	32.00
DIAGNOSTIC	07/11/88		12.50				12.50	0.00	12.50	80	10.00
DIAGNOSTIC	07/11/88		23.00				23.00	0.00	23.00	80	18.40
DIAGNOSTIC	07/11/88		3.00				3.00	0.00	3.00	80	2.40
DIAGNOSTIC	10/10/88		207.50		103.50	69	104.00	0.00	104.00	80	83.20
DIAGNOSTIC	10/10/88		13.50				13.50	0.00	13.50	80	10.80
D[illegible]OSTIC	10/10/88		23.00				23.00	0.00	23.00	80	18.40
D[illegible]OSTIC	10/10/88		3.00				3.00	0.00	3.00	80	2.40
PHYSICIAN SVC	10/10/88		40.00				40.00	0.00	40.00	80	32.00
		TOTALS	1037.50		313.50						579.20

-- PORTION OF CHARGE WHICH PRUDENTIAL HAS DETERMINED TO BE ABOVE THE RANGE OF USUAL AND PREVAILING FEES FOR THIS PROCEDURE IN YOUR PROVIDER'S AREA.
-- CHARGE PREVIOUSLY CONSIDERED UNDER BATCH #88111000702.
38 CHARGES PREVIOUSLY CONSIDERED.
69 IN EXCESS OF MAXIMUM ELIGIBLE CHARGE IN ACCORDANCE WITH THE TERMS OF THE PLAN.

TOTAL 579.20

CHECK # 0049221

PAGE 1

KEEP THIS RECORD FOR TAX PURPOSES.
NO OTHER RECORD WILL BE PROVIDED.

FORM #36858

50600143

PROCARE OF SOUTHERN CALIFORNIA
PRUDENTIAL PLUS OF SO CAL
PO BOX 85793
SAN DIEGO, CA 92138

(800) 433-3150

EXPLANATION OF BENEFITS
PRUDENTIAL INSURANCE COMPANY OF AMERICA

IF YOU HAVE ANY QUESTIONS ABOUT THIS CLAIM OR WISH A REVIEW OF THIS DECISION, PLEASE CONTACT THIS OFFICE.

DATE: JUNE 09, 1989
CONTROL#/BRANCH: 78207 01
ID#: [redacted]
EMPLOYEE: SAME AS PATIENT
PATIENT: ELEUTER V RAMOS
MMPD#: 6J6
CLAIM#: 89159000096 DB
PROVIDER NAME: FULLERTON INTERNAL MED

ELEUTER V RAMOS
2811 EAST VILLA REAL DRIV
ORANGE CA 92667

THIS IS NOT A BILL.

PAYMENT ISSUED TO PROVIDER(S) OF SERVICE.

NATURE OF SERVICE	DATES OF SERVICE		CHARGES	SUPPLE-MENTAL BENEFITS	EXCLUDED			DEDUCTIBLE		BENEFIT	
	FROM	TO			AMOUNT	CODE	AMT AFTER	APPLIED	AMT AFTER	%	AMOUNT
DIAGNOSTIC	01/09/89		12.50				12.50	12.50	0.00		0.00
DIAGNOSTIC	01/09/89		23.00				23.00	23.00	0.00		0.00
DIAGNOSTIC	01/09/89		3.00				3.00	3.00	0.00		0.00
PHYSICIAN SVC	01/09/89		40.00				40.00	40.00	0.00		0.00
DIAGNOSTIC	01/09/89		56.00				56.00	56.00	0.00		0.00
		TOTALS	134.50								0.00

-- THESE CHARGES HAVE BEEN APPLIED TO YOUR YEARLY DEDUCTIBLE.

TOTAL 0.00

PAGE 1

KEEP THIS RECORD FOR TAX PURPOSES. NO OTHER RECORD WILL BE PROVIDED.

FORM #86857

50600144

EXPLANATION OF BENEFITS
PRUDENTIAL INSURANCE COMPANY OF AMERICA

IF YOU HAVE ANY QUESTIONS ABOUT THIS CLAIM OR WISH A REVIEW OF THIS DECISION, PLEASE CONTACT ----------->

PRUCARE OF SO CALIFORNIA
PRUCARE OF SO CALIFORNIA
P. O. BOX 9315
VAN NUYS, CALIFORNIA 91409
(800) 433-3150

DATE: APRIL 21, 1988
CONTROL#/BRANCH: 78207 01
ID#: [redacted]
EMPLOYEE: SAME AS PATIENT
PATIENT: ELEUTER V RAMOS
MMPO#: 6J6
CLAIM#: 88111000702 DB
PROVIDER NAME: FULLERTON INTERNAL MED

ELEUTER V RAMOS
2811 EAST VILLA REAL DRIV
ORANGE CA 92667

THIS IS NOT A BILL.

PAYMENT ISSUED TO PROVIDER(S) OF SERVICE.

NATURE OF SERVICE	DATES OF SERVICE		CHARGES	SUPPLE-MENTAL BENEFITS	EXCLUDED			DEDUCTIBLE		BENEFIT	
	FROM	TO			AMOUNT	CODE	AMT AFTER	APPLIED	AMT AFTER	%	AMOUNT
DIAGNOSTIC	01/11/88		233.00	✓			233.00	200.00	33.00	80	26.40
PHYSICIAN SVC	01/11/88	02/08/88	74.00	✓			74.00	0.00	74.00	80	59.20
DIAGNOSTIC	01/11/88		56.00	✓			56.00	0.00	56.00	80	44.80
DIAGNOSTIC	02/08/88		210.00	✓			210.00	0.00	210.00	80	168.00
		TOTALS	573.00								298.40

-- YOUR YEARLY DEDUCTIBLE HAS BEEN SATIESFIED ON THIS CLAIM.

CHGS. DEDUCTIBLE
573.00 - 200.00 = 373.00
X .80
PD. 298.40

TOTAL 298.40

PAGE 1

KEEP THIS RECORD FOR TAX PURPOSES.
NO OTHER RECORD WILL BE PROVIDED.

FORM #86139

50600145

CLAIM FORM

5-7529-0

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME & ADDRESS
FATHER RAMOS
4462 CAMINO DE LA PLAZA
SUITE 370
SAN YSIDRO, CA
92073

2. PATIENT'S DATE OF BIRTH: 09 22 40

3. INSURED'S (SUBSCRIBER) NAME (First name, middle initial, last name)

5. PATIENT'S SEX — MALE: X FEMALE

6. INSURED'S (SUBSCRIBER) I.D. No. or **Medicare No.** (Include any letters)

7. PATIENT'S RELATIONSHIP TO INSURED — SELF: X SPOUSE CHILD OTHER

8. INSURED'S (SUBSCRIBER) GROUP NO. (Or Group Name)

9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number

10. WAS CONDITION RELATED TO
A. PATIENT'S EMPLOYMENT — YES NO
B. AN AUTO ACCIDENT — YES NO

11. INSURED'S (SUBSCRIBER) ADDRESS (Street, city, state, ZIP code)

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing)
I Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE/CHAMPUS Benefits Either to Myself or to the Party Who Accepts Assignment Below
SIGNED DATE

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
SIGNED (Insured or Authorized Person)

14. DATE OF — ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15. DATE FIRST CONSULTED PHYSICIAN FOR THIS CONDITION:

16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO

16A. IF AN EMERGENCY, CHECK HERE.

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY — FROM THROUGH

DATES OF PARTIAL DISABILITY — FROM THROUGH

19. NAME OF REFERRING PHYSICIAN

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES — ADMITTED DISCHARGED

21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)
INPATIENT HOSPITAL ST. JUDE HOSP-FULLERTON

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES NO: X CHARGES

PHYSICIAN OR SUPPLIER INFORMATION

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY — RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE
1. 25000
2. 25000
3. 5733
4. 2724

EPSDT YES NO
FAMILY PLANNING YES NO
PRIOR AUTHORIZATION NO.

24. A DATE OF SERVICE	B* PLACE OF SERVICE	C PROCEDURE CODE (IDENTIFY)	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS	E CHARGES	F PHYSICIAN'S NAME
03/14/88	IH	90215	HOSP ADMIT-INTERMEDIATE	25000	121.00	J BODWIN, MD
03/17/88	IH	90292	DISCHARGE-HOSPITAL CARE		63.00	J BODWIN, MD
03/15/88	IH	90250	HOSP VISIT-LIMITED		47.00	J BODWIN, MD
03/16/88	IH	90250	HOSP VISIT-LIMITED		47.00	J BODWIN, MD
04/11/88	O	90050	OFFICE VISIT	25000	40.00	J BODWIN, MD
04/11/88	O	99999	*	5733	0.00	J BODWIN, MD
04/11/88	O	99999	*	2724	0.00	J BODWIN, MD
04/11/88	O	80018 00	C	V726	49.50	J BODWIN, MD
04/11/88	O	84478 00	C	V726	22.00	J BODWIN, MD

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES NO

27. TOTAL CHARGES

28. AMOUNT PAID

29. BALANCE DUE

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.
FULLERTON INTR MEDICINE
433 WEST BASTANCHURY ROAD
FULLERTON, CALIF 92635

32. YOUR PATIENT'S ACCOUNT NO.

33. YOUR EMPLOYER I.D. NO.

I.D. NO.

50600146

HEALTH INSURANCE
CLAIM FORM

5-7529-0

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME & ADDRESS
FATHER RAMOS
4462 CAMINO DE LA PLAZA
SUITE 370
SAN YSIDRO, CA
92073

2. PATIENT'S DATE OF BIRTH: 02 22 40

3. INSURED'S (SUBSCRIBER) NAME (First name, middle initial, last name)

5. PATIENT'S SEX: MALE [✓] FEMALE [ ]

6. INSURED'S (SUBSCRIBER) I.D. No. or **Medicare No.** (include any letters)

7. PATIENT'S RELATIONSHIP TO INSURED: SELF [X] SPOUSE [ ] CHILD [ ] OTHER [ ]

8. INSURED'S (SUBSCRIBER) GROUP NO. (Or Group Name)

9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number

10. WAS CONDITION RELATED TO
A. PATIENT'S EMPLOYMENT: YES [ ] NO [ ]
B. AN AUTO ACCIDENT: YES [ ] NO [ ]

11. INSURED'S (SUBSCRIBER) ADDRESS (Street, city, state, ZIP code)

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing)
I Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE/CHAMPUS Benefits Either to Myself or to the Party Who Accepts Assignment Below
SIGNED DATE

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
SIGNED (Insured or Authorized Person)

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15. DATE FIRST CONSULTED PHYSICIAN FOR THIS CONDITION

16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES [ ] NO [ ]

16A. IF AN EMERGENCY, CHECK HERE [ ]

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY: FROM THROUGH

DATES OF PARTIAL DISABILITY: FROM THROUGH

19. NAME OF REFERRING PHYSICIAN

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED DISCHARGED

21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)
INPATIENT HOSPITAL ST. JUDE HOSP-FULLERTON

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [X] CHARGES

PHYSICIAN OR SUPPLIER INFORMATION

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE
1. V726
2. V726
3. 25000
4. 250

EPSDT YES [ ] NO [ ]
FAMILY PLANNING YES [ ] NO [ ]
PRIOR AUTHORIZATION NO.

24. A DATE OF SERVICE	B* PLACE OF SERVICE	C PROCEDURE CODE (IDENTIFY)	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS	E CHARGES	F PHYSICIAN'S NAME
04/11/88 0		81000 00		V726	12.50	J BODWIN, MD
04/11/88 0		83036 00	C	V726	23.00	J BODWIN, MD
07/11/88 0		90050	C OFFICE VISIT	25000	40.00	J BODWIN, MD
07/11/88 1		82947 00		250	[illegible]	J BODWIN, MD
07/11/88 0		83036 00	C	250	23.00	J BODWIN, MD
07/11/88 0		36415	C		3.00	J BODWIN, MD
10/10/88 0		80018 00		V726	49.50	J BODWIN, MD

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK): YES [ ] NO [ ]

27. TOTAL CHARGES

28. AMOUNT PAID

29. BALANCE DUE

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.
FULLERTON INTR MEDICINE
433 WEST BASTANCHURY ROAD
FULLERTON, CALIF 92635

I.D. NO.

32. YOUR PATIENT'S ACCOUNT NO.

33. YOUR EMPLOYER I.D. NO.

50600147

CLAIM FORM

5-7529-0

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME & ADDRESS
FATHER RAMOS
4462 CAMINO DE LA PLAZA
SUITE 370
SAN YSIDRO,CA
92073

2. PATIENT'S DATE OF BIRTH: 03 23 40

3. INSURED'S (SUBSCRIBER) NAME (First name, middle initial, last name)

5. PATIENT'S SEX: MALE ✓ FEMALE

6. INSURED'S (SUBSCRIBER) I.D. No. or **Medicare No.** (Include any letters)

7. PATIENT'S RELATIONSHIP TO INSURED: SELF X SPOUSE CHILD OTHER

8. INSURED'S (SUBSCRIBER) GROUP NO. (Or Group Name)

9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number

10. WAS CONDITION RELATED TO
A. PATIENT'S EMPLOYMENT YES NO
B. AN AUTO ACCIDENT YES NO

11. INSURED'S (SUBSCRIBER) ADDRESS (Street, city, state, ZIP code)

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing)
I Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE/CHAMPUS Benefits Either to Myself or to the Party Who Accepts Assignment Below

SIGNED DATE

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSTATED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW

SIGNED (Insured or Authorized Person)

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15. DATE FIRST CONSULTED PHYSICIAN FOR THIS CONDITION

16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO

16A. IF AN EMERGENCY, CHECK HERE.

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY FROM THROUGH

DATES OF PARTIAL DISABILITY FROM THROUGH

19. NAME OF REFERRING PHYSICIAN

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED

21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)
INPATIENT HOSPITAL ST. JUDE HOSP-FULLERTON

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES NO X CHARGES

PHYSICIAN OR SUPPLIER INFORMATION

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE
1. V726
2. V726
3. V726
4. V726

EPSDT YES NO
FAMILY PLANNING YES NO
PRIOR AUTHORIZATION NO.

24. A DATE OF SERVICE	B* PLACE OF SERVICE	C PROCEDURE CODE (IDENTIFY)	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS	E CHARGES	F PHYSICIAN'S NAME
10/10/88	C	84478 00	[redacted] C	V726	22.00	J BODWIN, MD
10/10/88	C	85022 00	[redacted] C	V726	25.00	J BODWIN, MD
10/10/88	C	85651 00	[redacted] C	V726	13.50	J BODWIN, MD
10/10/88	C	81000 00	[redacted] C	V726	12.50	J BODWIN, MD
10/10/88	C	83036 00	[redacted] C	V726	23.00	J BODWIN, MD
10/10/88	C	84479 00	[redacted] C	V726	22.00	J BODWIN, MD

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES NO

27. TOTAL CHARGES

28. AMOUNT PAID

29. BALANCE DUE

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO
FULLERTON INTR MEDICINE
433 WEST BASTANCHURY ROAD
FULLERTON,CALIF 92635

32. YOUR PATIENT'S ACCOUNT NO

33. YOUR EMPLOYER I.D. NO.

I.D. NO.

50600148

HEALTH INSURANCE
CLAIM FORM

5-7529-0

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME & ADDRESS
FATHER RAMOS
4462 CAMINO DE LA PLAZA
SUITE 370
SAN YSIDRO,CA
92073

2. PATIENT'S DATE OF BIRTH 02 23 40

3. INSURED'S (SUBSCRIBER) NAME (First name, middle initial, last name)

5. PATIENT'S SEX MALE X FEMALE

6. INSURED'S (SUBSCRIBER) I.D. No. or **Medicare No.** (Include any letters)

7. PATIENT'S RELATIONSHIP TO INSURED SELF X SPOUSE CHILD OTHER

8. INSURED'S (SUBSCRIBER) GROUP NO. (Or Group Name)

9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number

10. WAS CONDITION RELATED TO
A. PATIENT'S EMPLOYMENT YES NO
B. AN AUTO ACCIDENT YES NO

11. INSURED'S (SUBSCRIBER) ADDRESS (Street, city, state, ZIP code)

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing)
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SIGNED DATE

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SIGNED (Insured or Authorized Person)

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15. DATE FIRST CONSULTED PHYSICIAN FOR THIS CONDITION

16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO

16A. IF AN EMERGENCY, CHECK HERE.

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY FROM THROUGH

DATES OF PARTIAL DISABILITY FROM THROUGH

19. NAME OF REFERRING PHYSICIAN

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED

21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)
INPATIENT HOSPITAL ST. JUDE HOSP-FULLERTON

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES NO X CHARGES

PHYSICIAN OR SUPPLIER INFORMATION

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3 ETC. OR DX CODE
1. V726
2. V726
3. 2409
4. 5733

EPSDT YES NO
FAMILY PLANNING YES NO
PRIOR AUTHORIZATION NO

24. A DATE OF SERVICE	B PLACE OF SERVICE	C PROCEDURE CODE (IDENTIFY)	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS	E CHARGES	F PHYSICIAN'S NAME
10/10/88	C	84436 00	C	V726	29.50	J BODWIN, MD
10/10/88	C	84443 00	C	V726	47.00	J BODWIN, MD
10/10/88	C	36415			3.00	J BODWIN, MD
10/10/88	C	90050	OFFICE VISIT	2409	40.00	J BODWIN, MD
10/10/88	C	99999	*	5733	0.00	J BODWIN, MD
10/10/88	C	99999	*	2449	0.00	J BODWIN, MD
10/10/88	C	99999	*	2859	0.00	J BODWIN, MD
10/10/88	C	99999	*	25000	0.00	J BODWIN, MD
01/09/89	C	82947 00	C	250	12.50	J BODWIN, MD

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES NO

27. TOTAL CHARGES

28. AMOUNT PAID

29. BALANCE DUE

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO
FULLERTON INTR MEDICINE
433 WEST BASTANCHURY ROAD
FR,C 92635

32. YOUR PATIENT'S ACCOUNT NO

33. YOUR EMPLOYER I.D. NO

I.D. NO 50600149

PLEASE DO NOT STAPLE IN THIS AREA ➡

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

FORM APPROVED OMB NO. 0938-0008

☐ MEDICARE (MEDICARE NO.) ☐ MEDICAID (MEDICAID NO.) ☐ CHAMPUS (SPONSOR'S SSN) ☐ CHAMPVA (VA FILE NO.) ☐ FECA BLACK LUNG (SSN) ☐ OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. [PATIE]NT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): RAMOS FATHER
2. PATIENT'S DATE OF BIRTH: 03 | 23 | 40
3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE): 4462 CAMINO DE LA PLAZA, SUITE 370, SAN YSIDRO, CA 92073
   TELEPHONE NO.
5. PATIENT'S SEX: MALE [X] FEMALE [ ]
6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS)
7. PATIENT'S RELATIONSHIP TO INSURED: SELF [X] SPOUSE [ ] CHILD [ ] OTHER [ ]
8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)
   ☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)
10. WAS CONDITION RELATED TO:
    A. PATIENT'S EMPLOYMENT: YES [ ] NO [ ]
    B. ACCIDENT: AUTO [ ] OTHER [ ]
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
    TELEPHONE NO.
11.a. CHAMPUS SPONSOR'S: STATUS: ☐ ACTIVE DUTY ☐ DECEASED ☐ RETIRED — BRANCH OF SERVICE
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.
    SIGNED DATE
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.
    SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ◀ ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES
16.a. IF EMERGENCY CHECK HERE ☐
17. DATE PATIENT ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY: FROM THROUGH
    DATES OF PARTIAL DISABILITY: FROM THROUGH
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED DISCHARGED
21. [NA]ME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [X] CHARGES:
23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE
    1.
    2.
    3.
    4.
    B. EPSDT YES [ ] NO [ ]; FAMILY PLANNING YES [ ] NO [ ]
    PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE FROM TO	B.* PLACE OF SERVICE	C. PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G.* T.O.S.	H. LEAVE BLANK
01/11/88	3	90050		466.0	3700	✓		J BODWIN, MD
01/11/88	3	80018			4700	✓		J BODWIN, MD
01/11/88	3	84478			2100	✓		J BODWIN, MD
01/11/88	3	84479			2100	✓		J BODWIN, MD
01/11/88	3	84436			2800	✓		J BODWIN, MD
01/11/88	3	84443			4500	✓		J BODWIN, MD
01/11/88	3	83036			2200	✓		J BODWIN, MD
01/11/88	3	85022			2400	✓		J BODWIN, MD
01/11/88	3	85651			1300	✓ 223 40		J BODWIN, MD
01/11/88	3	81000			1200	✓		J BODWIN, MD
01/11/88	3	71020			5600	✓		J BODWIN, MD
02/08/88	3	93015		414.9	21000	✓		J BODWIN, MD

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)
    DATE:
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK): YES [ ] NO [ ]
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. YOUR SOCIAL SECURITY NO.
31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.: Fullerton Internal Medicine Clinic, 433 West Bastanchury Road, Fullerton, California 92635
    I.D. NO.
32. YOUR PATIENT'S ACCOUNT NO.
33. YOUR EMPLOYER I.D. NO.

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

REMARKS:

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (C-2) (1-84) Form OWCP-1500
Form CHAMPUS-501 Form RRB-1500

50600150

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

FORM APPROVED OMB NO. 0938-0008

☐ MEDICARE (MEDICARE NO.) ☐ MEDICAID (MEDICAID NO.) ☐ CHAMPUS (SPONSOR'S SSN) ☐ CHAMPVA (VA FILE NO.) ☐ FECA BLACK LUNG (SSN) ☐ OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): RAMOS FATHER
2. PATIENT'S DATE OF BIRTH: 03 | 23 | 40
3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE): 4462 CAMINO DE LA PLAZA SUITE 370 SAN YSIDRO, CA 92073

TELEPHONE NO.

5. PATIENT'S SEX: MALE [X] FEMALE ☐
6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS)
7. PATIENT'S RELATIONSHIP TO INSURED: SELF [X] SPOUSE ☐ CHILD ☐ OTHER ☐
8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.) ☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)
10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES ☐ NO ☐ B. ACCIDENT AUTO ☐ OTHER ☐
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO.

11.a. CHAMPUS SPONSOR'S: STATUS ☐ ACTIVE DUTY ☐ DECEASED ☐ RETIRED BRANCH OF SERVICE

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.

SIGNED DATE

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.

SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES
16.a. IF EMERGENCY CHECK HERE ☐
17. DATE PATIENT ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY FROM THROUGH

DATES OF PARTIAL DISABILITY FROM THROUGH

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐ CHARGES:
23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE

1.
2.
3.
4.

B. EPSDT YES ☐ NO ☐ FAMILY PLANNING YES ☐ NO ☐

PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE FROM TO	B.* PLACE OF SERVICE	C. PROCEDURE CODE (IDENTIFY)	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G.* T.O.S.	H. LEAVE BLANK
02/08/88	3	90050	OFFICE VISIT	414.0	37 00	✓		J BODWIN, MD
01/11/88	3	99999		250.00				
01/11/88	3	99999		240.9				
01/11/88	3	99999		573.3				
01/11/88	3	99999		272.4				
01/11/88	3	99999	POSSIBLE	244.9				

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)

DATE:

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES ☐ NO ☐
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. YOUR SOCIAL SECURITY NO.
31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO. Fullerton Internal Medicine Clinic 433 West Bastanchury Road Fullerton, California 92635

I.D. NO.

32. YOUR PATIENT'S ACCOUNT NO.
33. YOUR EMPLOYER I.D. NO.

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK REMARKS:

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (C-2) (1-84) Form OWCP-1500 Form CHAMPUS-501 Form RRB-1500

50600151

844

FULLERTON INTRN MEDICINE
P.O. BOX 5530
FULLERTON, CALIF. 92635

YOUR DOCTOR HAS INDICATED THAT HE WISHES TO ACCEPT "INSURANCE ONLY" ON YOUR ACCOUNT.

COPY

REFER TO THIS NUMBER ON ALL CORRESPONDENCE

STATEMENT OF ACCOUNT
WRITE CORRECTION ABOVE IF NAME OR ADDRESS SHOWN BELOW IS INCORRECT.

OFFICE PHONE NUMBER	ACCOUNT NO.	AMOUNT DUE	STATEMENT DATE	PAGE
714-879-7050	57529-0	573.00	032188	1

TYPE I

FATHER E.V. RAMOS
4462 CAMINO DE LA PLAZA
SUITE 370
SAN YSIDRO,CA
92073

SEND PAYMENTS AND INQUIRIES TO:
FULLERTON INTRN MEDICINE
433 W. BASTANCHURY RD
P.O. BOX 5530
FULLERTON, CALIF. 92635

AMOUNT PAID

DATE PAID

TEL. 83-1348

DETACH TOP PORTION AND RETURN WITH YOUR PAYMENT IN THE ENVELOPE PROVIDED. RETAIN ...

DATE	SERVICE RENDERED BY	DESCRIPTION		CHARGES	CREDITS
15 88		PREVIOUS BALANCE		813.90	
02 88	BODWIN, J	COURTESY WRITE-OFF 2-10-87	FATHER		153.00-
02 88	BODWIN, J	COURTESY WRITE-OFF 5-12-87	FATHER		21.20-
02 88	BODWIN, J	COURTESY WRITE-OFF 11-9-87	FATHER		14.20-
02 88	BODWIN, J	COURTESY WRITE-OFF 8-10-87	FATHER		14.20-
02 88	BODWIN, J	COURTESY WRITE-OFF 8-12, 11-10-86	FATHER		38.30-

ACCOUNT NO.	CLOSING DATE		PAST	30 DAYS	CURRENT	AMOUNT DUE
57529-0	032188		270.00	303.00		573.00

FULLERTON INTRN MEDICINE FULLERTON, CALIF. 92635
IRS. 95-2287265

50600159 207 1

ROMAN CATHOLIC BISHOP OF ORANGE
A CORPORATION SOLE
2811 E. VILLA REAL DRIVE
ORANGE, CA 92667

PAYEE NAME	VENDOR NO.
FULLERTON INTERNAL MEDICINE	1112

DATE	DESCRIPTION AND/OR INVOICE NO.	AMOUNT	REFERENCE
7/14/89	071189 MEDICAL-REV.ELEUTERIO RAMOS	579.20	465014
7/14/89	CHECK NUMBER 138098	579.20	

ROMAN CATHOLIC BISHOP OF ORANGE
A CORPORATION SOLE
2811 E. VILLA REAL DRIVE
ORANGE, CA 92667

16-66
1220

138098

BANK OF AMERICA
ORANGE MAIN OFFICE
345 EAST CHAPMAN AVENUE
ORANGE, CA 92668

CHECK NUMBER 138098

DATE 7/14/89

AMOUNT ******579.20

PAY EXACTLY ******579 DOLLARS AND 20 CENTS

PAY TO THE ORDER OF

NOT VALID AFTER 6 MONTHS
$25,000 OR OVER REQUIRES TWO SIGNATURES

FULLERTON INTERNAL MEDICINE

AUTHORIZED SIGNATURE

D & J BUSINESS FORMS (213) 691-7870

⑈138098⑈ ⑆122000661⑆ 02331⑈04006⑈

50600153

APPROVED OMB NO. 0938-0279

ST JUDE HOSPITAL & REHAB
DEPT LA 21028
PASADENA, CA 911851022
(714)871-3280

3 PATIENT CONTROL NUMBER

4 TYPE OF BILL: 111

5 BC/BS PROV. NO.

6 FEDERAL TAX NO.: 95-1643325

7 MEDICARE NO.

8 MEDICAID NO.

9

10 PATIENT'S LAST NAME / FIRST NAME / INITIAL	11 PATIENT'S ADDRESS / CITY / STATE / ZIP
RAMOS, ELEUTERIO V FATHER	4462 CAMINO DE LA PLAZ SAN YSIDRO, CA 92073

12 BIRTH DATE	13 SEX	14 MS	15 ADMISSION DATE	16 HR.	17 TYPE	18 SRC	19 A.H.	20 D.H.	21 STAT.	22 STATEMENT COVERS PERIOD FROM	THROUGH	23 COV.D.	24 N-C.D.	25 C-I.D.	26 L-R.D.	27
-23-40	M	S	03-14-88	08	3	1		13	01	03-14-88	03-17-88					C

28 OCCURRENCE CD DATE | 29 OCCURRENCE CD DATE | 30 OCCURRENCE CD DATE | 31 OCCURRENCE CD DATE | 32 OCCURRENCE CD DATE | 33 OCCURRENCE SPAN CD FROM THROUGH

34

RAMOS, ELEUTERIO V FATHER
4462 CAMINO DE LA PLAZA #370
SAN YSIDRO, CA 92073

CONDITION CODES 35 36 37 38 39 | BLOOD RECORD (PINTS) 40 FURN 41 REPL 42 NOT RP. 43 DED.: 0 | 44 SP. PROG. | 45: 294

46 VALUE CD	AMT	47 VALUE CD	AMT	48 VALUE CD	AMT	49 VALUE CD	AMT
a 01	335.00						

50 DESCRIPTION		51 R. CODE	52 S. UNITS	53 TOTAL CHARGES	54	55	56
ROOM-BOARD/PVT	35000	110	1	350.00			
ROOM BOARD/SEMI	33500	120	2	670.00			
PHARMACY		250		413.00			
LABORATORY		300		313.10			
[redacted]		350		454.00			
EDUC/TRAINING		942		285.00			
TOTAL		001		2485.10	.00		.00

To contact the representative handling this account please call (714) ~~871-3280~~ and ask for ext. ~~3001~~ 992-3034

Pd. in full
3/31/89

57 PAYER	58 REL. INFO	59 ASG. BEN.	60 DEDUCTIBLE	61 CO-INSURANCE	62 EST. RESPONSIBILITY	63 PRIOR PAYMENTS	64 EST. AMOUNT DUE
A P85 PRUDENTIAL INS CO	Y	Y					
B							
C							

DUE FROM PATIENT ▶

65 INSURED'S NAME	66 SEX	67 P. REL.	68 CERT.-SSN-HIC.-ID. NO.	69 GROUP NAME	70 INSURANCE GROUP NO.
A RAMOS, ELEUTERIO V FATHER	M	01		DIOCESE ORG	95545
B					
C					

71 EID	72 ESC	73 EMPLOYER NAME	74 EMPLOYEE ID.	75 EMPLOYER LOCATION
A	1	DIOCESE OF ORANGE		10 CALLE Y OCAMPO, TIJUANA, MX,

76 PRINCIPAL AND OTHER DIAGNOSES DESCRIPTIONS | 77 PRIN. CODE | OTHER DIAGNOSES CODES 78 79 80 81

82 P.C.: 9 | 83 PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS | 84 PRINCIPAL PROCEDURE CD DATE | 85 OTHER PROCEDURE CD DATE | 86 OTHER PROCEDURE CD DATE

PSRO UR DATA: 87 CD | 88 APP. FROM | 89 APP. THROUGH | 90 GRC.

91 TREATMENT AUTH.: B80767105

92 ATTENDING PHYSICIAN ID: BAG 046166 — BODWIN M.D., JEFFREY S.

93 OTHER PHYSICIAN ID.

94 REMARKS

DIOCESE OF ORANGE
2811 E. VILLA REAL DR.
ORANGE, CA 92667

VERIFIED N-C. STAY DATES FROM THROUGH | FOR INTERMEDIARY USE ONLY | PR. PSC. D. | 250.91

AMT. REIMBURSED | N-PYM. CD | APPROV. BY | DATE APPROV.

95 I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

PROVIDER REPRESENTATIVE X [signature]

96 DATE 03-30-88

UB-82 HCFA-1450 PAYER COPY 50600154

ST. JUDE HOSPITAL AND REHABILITATION CENTER
A Sisters of St. Joseph of Orange Corporation
101 East Valencia Mesa Drive, P.O. Box 4138
Fullerton, California 92634 (714) 871-3280
BUSINESS OFFICE HOURS: 8:00 A.M. – 4:30 P.M.
FED. I.D. # 95-1643325

TYPE BILL	PRINT DATE	CHARGES FROM	INCLUDED TO
INP FINAL	03/29/88	03/14	03/17 C

PATIENT'S NAME	PATIENT NUMBER	ADMISSION DATE	DISCHARGE DATE
IOS, ELEUTERIO V FATHER		03/14/88	03/17/88

RESPONSIBLE PARTY
ELEUTERIO V FATHER RAMOS
4462 CAMINO DE LA PLAZA #370
SAN YSIDRO, CA 92073

INSURANCE COVERAGE
1. F85 PRUDENTIAL INS CO

DATE	DESCRIPTION	RVS#	QTY	DEPT	CHG#	AMOUNT
03/14/88	ROOM 577	.00	1	90	057701	350.00
	TOTAL 110 ROOM-BOARD/PVT					350.00
03/15/88	ROOM 471	.00	1	90	047101	335.00
03/16/88	ROOM 471	.00	1	90	047101	335.00
	TOTAL 120 ROOM BOARD/SEMI					670.00
03/14/88		15669.00	1	30	156690	56.50
03/15/88		15669.00	1	30	156693	56.50
03/15/88		2476.00	1	30	24760	15.50
03/15/88		2476.00	1	30	24763	9.00
03/16/88		2476.00	1	30	24763	9.00
03/16/88	H	21600.00	1	30	216005	21.00
03/16/88		21600.00	1	30	216000	21.00
03/16/88		2476.00	1	30	24760	15.50
03/16/88		2476.00	1	30	24761	50.00
03/16/88		50.00	1	30	503	159.00
	TOTAL 250 PHARMACY					413.00
03/14/88		85024.00	1	31	390	48.50
03/14/88		82947.00	1	31	8030	26.00
03/14/88		80112.00	1	31	10340	40.00
03/14/88		82947.00	1	31	8030	26.00
03/14/88		82947.00	1	31	8030	26.00
03/14/88		96000.00	1	31	42011	9.80
03/14/88		82947.00	1	31	8030	-26.00
03/14/88		96000.00	1	31	42011	9.80
03/14/88		96000.00	1	31	42011	9.80
03/15/88		82947.00	1	31	8030	26.00
03/15/88		82947.00	1	31	8030	26.00
03/15/88		82947.00	1	31	8030	26.00
03/15/88		82947.00	1	31	8030	26.00
03/15/88		96000.00	1	31	42011	9.80
03/15/88		96000.00	1	31	42011	9.80
03/15/88		96000.00	1	31	42011	9.80
03/15/88		96000.00	1	31	42011	9.80

50600155

NOTICE TO THE PATIENT: THE HOSPITAL IS ACTING SOLELY AS AN AGENT FOR THE PATIENT IN FILING FOR INSURANCE BENEFITS ASSIGNED TO IT. HOWEVER, THE HOSPITAL CAN ASSUME NO RESPONSIBILITY FOR GUARANTEEING PAYMENT OF COVERED CHARGES AS SHOWN ON THE FACE OF THE BILL. CREDIT IS SHOWN ONLY WHEN THE HOSPITAL HAS ACTUALLY RECEIVED PAYMENT. SHOULD AN OVERPAYMENT BE MADE, A REFUND CHECK WILL BE SENT TO THE AUTHORIZED PARTY THAT IS DUE THE OVERPAYMENT

st. jude hospital and rehabilitation center
A Sisters of St. Joseph of Orange Corporation
101 East Valencia Mesa Drive, P.O. Box 4138
Fullerton, California 92634 (714) 871-3280
BUSINESS OFFICE HOURS: 8:00 A.M. – 4:30 P.M.

FED. I.D. #
95-1643325

PAT. TYPE BILL	PRINT DATE	CHARGES FROM	INCLUDED TO
INP FINAL	03/29/88	03/14	03/17 C

PATIENT'S NAME	PATIENT NUMBER	ADMISSION DATE	DISCHARGE DATE
[OS,ELEUTERIO V FATHER		03/14/88	03/17/88

RESPONSIBLE PARTY

ELEUTERIO V FATHER RAMOS
4462 CAMINO DE LA PLAZA #370
SAN YSIDRO, CA 92073

INSURANCE COVERAGE

1. P85 PRUDENTIAL INS CO

DATE	DESCRIPTION	RVS#	QTY	DEPT	CHG#	AMOUNT
03/16/88		82947.00	1	31	8030	26.00
03/16/88		82947.00	1	31	8030	26.00
03/16/88		82947.00	1	31	8030	26.00
03/16/88		82947.00	1	31	8030	26.00
03/16/88		82947.00	1	31	8030	-26.00
03/16/88		82947.00	1	31	8030	-26.00
03/16/88		82947.00	1	31	8030	-26.00
03/16/88		82947.00	1	31	8030	-26.00
03/17/88		82947.00	1	31	8030	26.00
03/17/88		82947.00	1	31	8030	26.00
0[illegible]/17/88		82947.00	1	31	8030	26.00
[illegible]7/88		82947.00	1	31	8030	26.00
03/17/88		82947.00	1	31	8030	-26.00
03/17/88		82947.00	1	31	8030	-26.00
03/17/88		82947.00	1	31	8030	-26.00
03/17/88		82947.00	1	31	8030	-26.00
	TOTAL 300 LABORATORY					313.10
03/15/88		70470.00	1	47	740	454.00
	T					454.00
03/14/88		99032.00	1	49	104	55.00
03/16/88		99032.00	1	49	102	55.00
03/16/88	G	99032.00	1	49	103	55.00
03/16/88		99032.00	2	49	111	40.00
03/16/88		99032.00	2	49	112	40.00
03/17/88		99032.00	1	49	111	20.00
03/17/88		99032.00	1	49	112	20.00
	TOTAL 942 EDUC/TRAINING					285.00

BALANCE 2485.10

50600156

NOTICE TO THE PATIENT: THE HOSPITAL IS ACTING SOLELY AS AN AGENT FOR THE PATIENT IN FILING FOR INSURANCE BENEFITS ASSIGNED TO IT. HOWEVER, THE HOSPITAL CAN ASSUME NO RESPONSIBILITY FOR GUARANTEEING PAYMENT OF COVERED CHARGES AS SHOWN ON THE FACE OF THE BILL. CREDIT IS SHOWN ONLY WHEN THE HOSPITAL HAS ACTUALLY RECEIVED PAYMENT. SHOULD AN OVERPAYMENT BE MADE, A REFUND CHECK WILL BE SENT TO THE AUTHORIZED PARTY THAT IS DUE THE OVERPAYMENT

FORM APPROVED
OMB NO 0938-0008

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

[ ] MEDICARE (MEDICARE NO.) [ ] MEDICAID (MEDICAID NO.) [ ] CHAMPUS (SPONSOR'S SSN) [ ] CHAMPVA (VA FILE NO.) [ ] FECA BLACK LUNG (SSN) [X] OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): ELEUTERIO RAMOS
2. PATIENT'S DATE OF BIRTH: 03 | 23 | 40
3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): ELEUTERIO RAMOS
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE): 4462 CAMINO DELAPLAZA #370 SAN YSIDRO CA 92073
TELEPHONE NO (714) 683-1348
5. PATIENT'S SEX: MALE [X] FEMALE [ ]
6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS)
7. PATIENT'S RELATIONSHIP TO INSURED: SELF [X] SPOUSE [ ] CHILD [ ] OTHER [ ]
8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)
[ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)
10. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES [ ] NO [ ]
B. ACCIDENT AUTO [ ] OTHER [ ]
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE): DIOCESE OF ORANGE
TELEPHONE NO
11.a CHAMPUS SPONSOR'S STATUS [ ] ACTIVE DUTY [ ] DECEASED [ ] RETIRED BRANCH OF SERVICE
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW
SIGNED SIGNATURE ON FILE DATE
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
SIGNATURE ON FILE
SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ◄ ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES
16.a IF EMERGENCY CHECK HERE [ ]
17. DATE PATIENT ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY): J.S. BODWIN, M.D. 00G46166
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE): ST. JUDE HOSPITAL 101 E. VALENCIA MESA
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [ ] CHARGES
23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE
1. [redacted]
2.
3.
4.
B. EPSDT YES [ ] NO [ ]
FAMILY PLANNING YES [ ] NO [ ]
PRIOR AUTHORIZATION NO

24. A DATE OF SERVICE FROM TO	B.* PLACE OF SERVICE	C. PROCEDURE CODE (IDENTIFY)	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E. CHARGES	F DAYS OR UNITS	G.* TOS	H. LEAVE BLANK
03/15/88	1	70470-26	[redacted] W/O CNTRST FLLWD BY CONTRAST	250.0	210 00		4	

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)
DATE 04/18/88
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES [ ] NO [ ]
27. TOTAL CHARGE: 210 00
28. AMOUNT PAID: 0 00
29. BALANCE DUE: 210 00
30. YOUR SOCIAL SECURITY NO.
31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO: ST. JUDE RAD MED GRP, INC P.O. BOX 5007 FULLERTON, CA 92635 (714) 879-9020
I.D. NO.
32. YOUR PATIENT'S ACCOUNT NO: [redacted]
33. YOUR EMPLOYER I.D. NO: [redacted]

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK
REMARKS

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (2) (SC) (1-84) Form OWCP-1500
Form CHAMPUS-501 Form RRB-1500

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